DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 1 3

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.40, .60,.100, 447 Subpart B 447.200 and 493

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 11,633,400
b. FFY 2002 $ 11,633,400

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A pages 5, 7.1.3,7.2.1(b) 7.2.1(c), 7.2.1(d),7.4.1, 7.5.2,
Attachment 3.1-B pages 5, 16, 18, 23, 23.1 23.2, 28,
Attachment 4.19-B pages 20.6, 20.7, 20.9, 20.9(a), 20.24, 20.24(a)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
* Effective date of 09/11/00 for the following pages:
Attachment 3.1-A, pages 7.2.1(c), 7.2.1(d)
Attachment 3.1-B, pages 23.1, 23.2
Attachment 4.19-B, pages 20.24, 20.24(a)

10. SUBJECT OF AMENDMENT:
Reimbursement methodologies for Dental, Vision and ARNP services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Review delegated to Commissioner Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dennis Boyd

14. TITLE:
Commissioner Dept for Medicaid Services

15. DATE SUBMITTED: 9/27/00

16. RETURN TO:
Sharon A. Rodriguez, Manager
Policy Coordination Branch
Department for Medicaid Services
275 East Main Street 6EA
Frankfort, KY 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 29, 2000

18. DATE APPROVED:
June 14, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Granger

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:
* State agency authorized "pen and ink" change to Section 9. State plan approved with effective dates of 07/01/00 and 09/11/00.

FORM HCFA-179 (07-92)

Instructions on Back

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided

b. Dentures.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

d. Eyeglasses

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

*Description provided on attachment.

(1) In-hospital Care

Medicaid reimbursement shall be made for a medically necessary dental service provided by a dentist in an inpatient or outpatient hospital setting if:

(a) The Medicaid recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if the dental service was provided in the dentist's office; and

(b) In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in the inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

B. Hearing Services

Audiological Benefits

(a) Coverage is limited to the following services provided by certified audiologists:

1) Complete hearing evaluation;
2) Hearing aid evaluation;
3) A maximum of three follow-up visits within the six month period immediately following fitting of a hearing aid, such visits to be related to the proper fit and adjustment of that hearing aid; and
4) One follow-up visit six months following fitting of a hearing aid, to assure a patient's successful use of the aid.

(b) Services not listed above will be provided when medically necessary upon appropriate pre-authorization.

(6) Medical care and Any Other Type of Remedial Care

(b) Optometrists' services are provided to both the categorically needy and the medically needy. Such coverage includes writing of prescriptions, diagnosis, and provision of treatment to the extent such services are within the lawful scope of practice (licensed authority) of optometrists licensed in the state of Kentucky. The following limitations are also applicable:

1) Provision of eyeglasses is limited to recipients under age twenty-one (21).
2) Contact lenses are not covered.
3) Telephone contacts are not covered.
4) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.
5) If medically necessary, prisms shall be added within the cost of the lenses.

(c) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

6. Medical Care and Any Other Type of Remedial Care

d. Other practitioner's services

Advanced Registered Nurse Practitioner (ARNP) Services

(1) An ARNP covered service shall be a medically necessary service provided within the legal scope of practice of the ARNP and furnished through direct practitioner-patient interaction so long as that service is eligible for reimbursement by Kentucky Medicaid.

(2) ARNP's participating as nurse-midwives or nurse anesthetists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.

(3) An ARNP desiring to participate in the Medical Assistance Program shall:

(a) Meet all applicable requirements of state laws and conditions for practice as a licensed ARNP;
(b) Enter into a provider agreement with the Department for Medicaid Services to provide services;
(c) Accompany each participation application with a current copy of the ARNP's license; and
(d) Provide and bill for the services in accordance with the terms and conditions of the provider participation agreement.

(4) Administration of anesthesia by an ARNP is a covered service.

(5) The cost of the following injectables administered by an ARNP in a physician or other independent practitioner's office shall be covered:
a. Rho (D) immune globulin injection;
b. Injectable anticancer chemotherapy administered to a recipient with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare;
c. Depo-Provera contraceptive injection;
d. Penicillin G and ceftriaxone injectable antibiotics; and
e. Epidural injections administered for pain control.

(6) An outpatient laboratory procedure by an ARNP who has been certified in accordance with 42 CFR, Part 493 shall be covered.

(7) An obstetrical and gynecological service provided by an ARNP shall be covered as follows:

a. An annual gynecological examination;
b. An insertion of an intrauterine device (IUD), including the cost of the device, or removal of the IUD;
c. The insertion of an implantable contraceptive capsule, including the cost of the contraceptive capsule and related supplies, or removal of the capsule;
d. Prenatal care;
e. A routine newborn service to an infant born to a Kentucky Medicaid eligible recipient; and
f. A delivery service, which shall include:
    1. Admission to the hospital;
    2. Admission history;
    3. Physical examination,
    4. Anesthesia;
    5. Management of uncomplicated labor;
    6. Vaginal delivery; and
    7. Postpartum care.

(8) An EPSDT screening service provided in compliance with a periodicity schedule developed in conjunction with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health shall be covered.

(9) A limitation on a service provided by a physican as described in Attachment 3.1-A, pages 7.21, 7.21(a) and 7.21(a)(o) shall also apply if the service is provided by an ARNP.

(10) The same service provided by an ARNP and a physician on the same day within a common practice shall be considered as one (1) covered service.

13. Dental Services

A. A listing of dental services available to recipients age 21 and over is maintained at the central office of the single state agency and is shown in the provider manual.

Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

B. Out-of Hospital Dental Services

A listing of dental services available to Medicaid recipient is maintained at the central office of the single state agency and is shown in the provider manual.

C. In-Hospital Care

Reimbursement shall be made for a medically necessary dental service provided by a dentist in an inpatient or outpatient hospital setting if:

(a) The Medicaid recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if the dental service was provided in the dentist's office; and

(b) In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in the inpatient or outpatient hospital setting due to the recipient's physical, mental or behavioral condition.

Prosthetic Services (continued)

Orthopedic shoes not attached to braces may be provided as medically necessary, subject to prior authorization.

D. Eyeglasses.

(1) Coverage for eyeglasses is limited to children under age 21 with prior authorization of the service required. Coverage is further restricted to a maximum of two (2) pairs of eyeglasses per year per person. This limitation includes the initial eyeglasses and one (1) replacement pair per year or two (2) replacements per year.

(2) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED MEDICALLY NEEDY GROUP(S): ALL

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Screening services.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Preventive services.

☒ Provided: ☐ No limitations ☒ With limitations*

d. Rehabilitative services.

☒ Provided: ☐ No limitations ☒ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*

b. Nursing facility services.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description of limitations provided on attachment.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found.

A. Dental Services

(1) Out-of-Hospital Care

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency and shown in provider manual.

Services not listed in the provider manual will be pre-authorized when medically necessary.

(2) In-Hospital Care

Medicaid reimbursement shall be made for a medically necessary dental service provided by a dentist in an inpatient or outpatient hospital setting if:

(a) The Medicaid recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if the dental service was provided in the dentist's office; and

(b) In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in the inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

(b) Exception to the above limitations may be made through pre-authorization if medical necessity is indicated in the individual case.

(2) Hearing Aid Benefits

Coverage is provided on a pre-authorized basis for any hearing aid model recommended by a certified audiologist so long as that model is available through a Medicaid participating hearing aid dealer.

C. Vision Care Services

Optometrists' services are provided to children under 21 years of age. Coverage includes writing of prescriptions, services to frames and lenses, and diagnostic services provided by ophthalmologists and optometrists, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses are provided only to children under age 21 on a pre-authorized basis. Coverage for eyeglasses is limited to two (2) pairs of eyeglasses per year per person. This limitation includes the initial eyeglasses and one (1) replacement per year or two (2) replacements per year. All services, other than examinations or diagnosis procedures, must be prior authorized. If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

(6) Medical care and Any Other Type of Remedial Care

(a) Optometrists' services are provided to both the categorically needy and the medically needy. Such coverage includes writing of prescriptions, diagnosis, and provision of treatment to the extent such services are within the lawful scope of practice (licensed authority) of optometrists licensed in the state of Kentucky. The following limitations are also applicable:

1) Provision of eyeglasses is limited to recipients under the age of twenty-one (21).
2) Telephone contacts are not covered.
3) Contact lens are not covered;
4) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

(b) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

6. Medical Care and Any Other Type of Remedial Care

d. Other practitioner's services

Advanced Registered Nurse Practitioner (ARNP) Services

(1) An ARNP covered service shall be a medically necessary service provided within the legal scope of practice of the ARNP and furnished through direct practitioner-patient interaction so long as that service is eligible for reimbursement by Kentucky Medicaid.

(2) ARNP's participating as nurse-midwives or nurse anesthetists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.

(3) An ARNP desiring to participate in the Medical Assistance Program shall:
- (a) Meet all applicable requirements of state laws and conditions for practice as a licensed ARNP;
- (b) Enter into a provider agreement with the Department for Medicaid Services to provide services;
- (c) Accompany each participation application with a current copy of the ARNP's license; and
- (d) Provide and bill for services in accordance with the terms and conditions of the provider participation agreement.

(4) Administration of anesthesia by an ARNP is a covered service.

(5) The cost of the following injectables administered by an ARNP in a physician or other independent practitioner's office shall be covered:
- a. Rho (D) immune globulin injection;
- b. Injectable anticancer chemotherapy administered to a recipient with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare;
- c. Depo-Provera contraceptive injection;
- d. Penicillin G and ceftriaxone injectable antibiotics; and
- e. Epidural injections administered for pain control.

(6) An outpatient laboratory procedure by an ARNP who has been certified in accordance with 42 CFR, Part 493 shall be covered.

(7) An obstetrical and gynecological service provided by an ARNP shall be covered as follows:

a. An annual gynecological examination;
b. An insertion of an intrauterine device (IUD), including the cost of the device, or removal of the IUD;
c. The insertion of an implantable contraceptive capsule, including the cost of the contraceptive capsule and related supplies, or removal of the capsule;
d. Prenatal care;
e. A routine newborn service to an infant born to a Kentucky Medicaid eligible recipient; and
f. A delivery service, which shall include:
    1. Admission to the hospital;
    2. Admission history;
    3. Physical examination,
    4. Anesthesia;
    5. Management of uncomplicated labor;
    6. Vaginal delivery; and
    7. Postpartum care.

(8) An EPSDT screening service provided in compliance with a periodicity schedule developed in conjunction with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health shall be covered.

(9) A limitation on a service provided by a physician as described in Attachment 3.1-B, pages 21, 22 and 22.1(a) shall also apply if the service is provided by an ARNP.

(10) The same service provided by an ARNP and a physician on the same day within a common practice shall be considered as one (1) covered service.

C. In-Hospital Care

Medicaid reimbursement shall be made for a medically necessary dental service provided by a dentist in an inpatient or outpatient hospital setting if:

(a) The Medicaid recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if the dental service was provided in the dentist's office; and

(b) In accordance with generally accepted standards of good dental practice, the dental service would customarily be [provided in the inpatient or outpatient hospital setting due to the recipient's physical, mental or behavioral condition.

Prosthetic Devices (continued)

Orthopedic shoes not attached to braces may be provided as medically necessary, subject to prior authorization.

D. Eyeglasses

(1) Coverage for eyeglasses is limited to children under age 21 with prior authorization of the service required. Coverage if further restricted to a maximum of two (2) pairs of eyeglasses per year per person. This limitation includes the initial eyeglasses and one (1) replacement pair per year or two (2) replacements per year.

(2) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

III. Dental Services

A. Definitions.

For purposes of determination of payment usual and customary actual billed charge refers to the uniform amount the individual dentist charges in the majority of cases for a specific dental procedure or service.

B. Reimbursement for Outpatient and Inpatient Services.

(1) The department shall reimburse participating dentists for covered services provided to eligible Medicaid recipients at the dentist's actual billed charge not to exceed the fixed upper limit per procedure established by the department.

(2) With the exceptions specified in section (3), (4), and (5), the upper payment limit per procedure shall be established by increasing the limit in effect on 6/30/00 by 32.78%, rounded to the nearest dollar. This rate of increase is based upon an allocation of funds by the 2000 Kentucky General Assembly and a comparison to rates of other states rates based upon a survey of Dental Fees by the American Dental Association.

(3) If an upper payment limit is not established for a covered dental service in accordance with (2) above, the department shall establish an upper payment limit by the following:

a. The state will obtain no less than three (3) rates from other sources such as Medicare, Workmen's Compensation, private insurers or three (3) high volume Medicaid providers:
b. An average limit based upon these rates will be calculated; and
c. The calculated limit will be compared to rates for similar procedures to assure consistency with reimbursement for comparable services.

(4) The following reimbursement shall apply:

a. Orthodontic Consultation, $112.00, except that a fixed fee of $56.00 shall be paid if:
   1. The provider is referring a recipient to a medical specialist;
   2. The prior authorization for orthodontic services is not approved; or
   3. A request for prior authorization for orthodontic services is not made.

b. Prior authorized early phase orthodontic services for moderately severe disabling malocclusions, $1,367 for orthodontists and $1,234 for general dentists.

c. Prior authorized orthodontic services for moderately severe disabling malocclusions, $2,754 for orthodontists and $1,649 for general dentists.

d. Prior authorized orthodontic services for severe disabling malocclusions, $2,754 for orthodontists and $2,455 for general dentists.

e. Prior authorized services for Temporomandibular Joint (TMJ) therapy, an assessed rate per service not to exceed $424

(5) This reimbursement methodology does not apply to oral surgeons' services that are included within the scope of their licenses. Those services are reimbursed in accordance with the reimbursement methodology for physician services.

(6) Medicaid reimbursement shall be made for medically necessary dental services provided in an inpatient or outpatient setting if:

a. The recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if provided in a dentist's office; and
b. In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in an inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

IV. Vision Care Services

A. Definitions.

For purposes of determination of payment, "usual and customary actual billed charge" refers to the uniform amount the individual optometrist or ophthalmic dispenser charges in the majority of cases for a specific procedure or service.

B. Reimbursement for Covered Procedures and Materials for Optometrists.

(1) Reimbursement for covered services, within the optometrist's scope of licensure, except materials and laboratory services, shall be based on the optometrists' usual and customary actual billed charges up to the fixed upper limit per procedure established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS). Fixed upper limits not determined in accordance with the RBRVS methodology (due to factors such as availability) shall be set by the department using the following methodology.

The fixed upper limit for the procedure shall be consistent with the general array of rates for the type of service. "General array of fixed rates" means that the rate upper limit set for the procedure will be at the same relative level, so far as possible, as the rates for procedures which are similar in nature. The listing of similar services is referred to as the "general array." The actual upper limit is derived by using not less than 3 other sources such as Medicare, Workman's Compensation, other federal programs, other state or local governments, and health insurance organizations or if a rate is not available from these sources then we solicit rates from at least 3 of the highest volume instate providers of the services. After obtaining at least 3 rates, the rates are added together then divided by the number of rates to obtain an average rate which is then compared to similar procedures paid in comparable circumstances by the Medicaid program to set the upper limit.

(2) With the exception of rates paid for dispensing services, fixed upper limits for vision services shall be calculated using the same RBRVS units as those used in the physicians services program, with the units multiplied by the "all other services" conversion factor to arrive at the fixed upper limit for each procedure.

(3) The upper payment limit for the following dispensing services shall be established by increasing the limit in effect on 6/30/00 to a fee no less than the Medicare allowable fee established for the service

(a) Fitting of spectacles;
(b) Special spectacles fitting; and
(c) Repair and adjustment of spectacles.

(4) Reimbursement for materials (eyeglasses or parts of eyeglasses) shall be made at the optical laboratory cost of the materials not to exceed upper limits for materials as set by the department. An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for post-payment review. The agency upper limits for materials are set based on the agency's best estimate of reasonable and economical rates at which the materials are widely and

consistently available, taking into consideration statewide billing practices, amounts paid by Medicaid programs in selected comparable states, and consultation with the optometry Technical Advisory Committee of the Medical Assistance Advisory Council as to the reasonableness of the proposed upper limits.

(5) Laboratory services shall be reimbursed at the actual billed amount not to exceed Medicare allowable reimbursement rates. If there is no established Medicare allowable reimbursement rate, the payment shall be sixty-five (65) percent of usual and customary actual billed charges.

C. Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers

Reimbursement for a covered service within the ophthalmic dispenser's scope of licensure shall be as described in Section B (above).

D. Effect of Third Party Liability

When payment for a covered service is due and payable from a third party source, such as private insurance, or some other third party with a legal obligation to pay, the amount payable by the department shall be reduced by the amount of the third party payment.

XXV. Advanced Registered Nurse Practitioner Services

(1) Reimbursement

a. Participating licensed advanced registered nurse practitioners (ARNP) shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of a licensed ARNP.

b. Except as specified in subsection c of this section or Section 2 below, reimbursement for a procedure provided by an ARNP shall be at the lesser of the following:
   1. The ARNP's actual billed charge for the service; or
   2. Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service.

c. An ARNP employed by a primary care center, federally qualified health center, hospital, or comprehensive care center shall not be reimbursed directly for services provide in that setting while operating as an employee.

(2) Reimbursement Limitations.

a. The fee for administration of a vaccine to a Medicaid recipient under the age of twenty-one (21) by an ARNP shall be three (3) dollars and thirty (30) cents up to three (3) administrations per ARNP, per recipient, per date of service.

b. The cost of a vaccine available free through the Vaccines for Children Program shall not be reimbursed.

c. Injectable antibiotics, antineoplastic chemotherapy, and contraceptives shall be reimbursed at the lesser of:
   1. The actual billed charge; or
   2. The average wholesale price of the medication supply minus ten (10) percent.

d. Reimbursement for an anesthesia service provided during a procedure shall be inclusive of the following elements:
   1. Preoperative and post-operative visits;
   2. Administration of the anesthetic;
   3. Administration of intravenous fluids and blood or blood products incidental to the anesthesia or surgery;
   4. Post-operative pain management; and
   5. Monitoring services.

e. Reimbursement of a psychiatric service provided by an ARNP shall be limited to four (4) psychiatric services per ARNP, per recipient, per twelve (12) months.

f. Reimbursement for a laboratory service provided in an office setting shall be inclusive of:
   1. The fee for collecting and analyzing the specimen; and
   2. Should the test require an arterial puncture or venipuncture, the fee for the puncture.

g. Reimbursement shall be limited to one (1) of the following evaluation and management services performed by an ARNP per recipient, per date of service:
   1. A consultation service;
   2. A critical care service;
   3. An emergency department evaluation and management service;
   4. A home evaluation and management service;
   5. A hospital inpatient evaluation and management service;
   6. A nursing facility service;
   7. An office or other outpatient evaluation and management service;
   8. A preventive medicine service; or
   9. A psychiatric or other psychotherapy service.